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No. 06-839

IN THE
Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R. FOTI, JR., Attorney General for the State of Louisiana; DAUTERIVE HOSPITAL,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the Louisiana Assignment Statute, Louisiana Revised Statute § 40:2010, is expressly preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a).

2. Whether the Louisiana Assignment Statute duplicates or otherwise conflicts with the cause of action for benefits set forth in ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

RULE 29.6 STATEMENT

Pursuant to Rule 29.6, Respondents Rapides Healthcare System and Dauterive Hospital state the following:

Rapides Healthcare System, L.L.C. is 75 % owned by (1) Galen Holdco, L.L.C. (66.77%), which owns Rapides' parent corporations, the Galen Virginia Hospital Corporation, WGH, Inc., Extendicare Properties, Inc., Columbia/HCA Healthcare Corporation of Central Louisiana, and Galen LA, L.L.C., and (2) Galen LA, L.L.C. (7.23%). Galen Holdco, L.L.C. and Galen LA, L.L.C. are the wholly-owned subsidiaries of Healthtrust, Inc.-The Hospital Company. Healthtrust, Inc.-The Hospital Company is a wholly-owned subsidiary of HCA, Inc. a privately-held corporation. The Rapides Foundation, a tax-exempt not-for-profit corporation, owns the remaining 26% of Rapides Healthcare system, L.L.C.

Dauterive Hospital is wholly owned by the Dauterive Hospital Corporation which, through its parent HTI Hospital Holdings, Inc., and grandparent Healthtrust, Inc.-The Hospital Company is a wholly-owned subsidiary of HCA Inc.

An ownership of more than 10% in both Dauterive Hospital and the Rapides Healthcare System is held by Merrill Lynch & Co., Inc., a publicly-traded company.

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STATEMENT OF THE CASE

The Louisiana Assignment Statute, codified at Louisiana Revised Statute § 40:2010 ("Assignment Statute"), regulates the health insurance claims process by requiring that all entities indemnifying a patient for health care expenses honor the patient's assignment of heath care benefits to a hospital. Consistent with the aims of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, the Assignment Statute thus facilitates employees' receipt of their welfare benefits by removing an unnecessary middleman (the patient) from the claims process. Refusing to honor assignments inflicts a deadweight loss on the entire health care system by forcing the provider to pursue a separate claim against the patient, who may be unwilling or unqualified to pursue the insurance benefits to which he or she is entitled, or simply reluctant to turn them over to the hospital after collecting them.

The Petitioner, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross"), has no legitimate interest in imposing those costs on patients or the system, but wants to brandish the threat to increase its leverage in negotiations with hospitals. If Blue Cross wants to incentivize hospitals to join its network, it can do so by limiting coverage or reimbursement rates for out-of-network care. Blue Cross knows its own insureds would react badly to those moves, and simply wants to coerce providers into network so that it can lower its own reimbursement payments in a way that its insureds will not notice or understand. That tactic serves no public interest.

The Fifth Circuit correctly held that the Assignment Statute is fully consistent with the text and purposes of ERISA, and is not preempted. That decision does not conflict with any decision of this Court or of any other Circuit. The Petition should be denied.

Factual Background

Rapides Healthcare System ("Rapides") is a community health care system based in Alexandria, Louisiana,

operating hospitals throughout central Louisiana. Dauterive Hospital ("Dauterive") is a community hospital located in New Iberia, Louisiana. R. 9:1588-92. Both Rapides and Dauterive (the "Hospitals") serve patients who are covered by ERISA and non-ERISA policies and plans insured or administered by Blue Cross. *Id.*

In lieu of advance payment, the Hospitals routinely accept assignments of benefits from their patients, including patients insured by Blue Cross. R. 9:1590. The Louisiana Assignment Statute builds on the insurance claims process utilized by every insurer in the state and throughout the country. Under that process, a hospital notifies an insurer on the National Uniform Bill (today, termed a UB-92), which it submits on the patient's behalf. La. Rev. Stat. Ann. §§ 22:213(A)(14), 22:214.3(A). That form includes a space for the hospital to notify the insurer of an assignment.

For many years, while the Hospitals were considered "in network," Blue Cross accepted the electronic submission of the Hospitals' claims on the National Uniform Bill, including the notification of assignments of benefits, and paid assigned benefits directly to the Hospitals. R. 6:1012-13, 1015. In October of 1999, however, after lengthy but unsuccessful negotiations regarding reimbursement rates, Rapides terminated its Network Provider Agreement with Blue Cross. R. 6:1015. Despite the contract's termination, Rapides continued to treat patients covered by Blue Cross plans, and continued to accept assignments of benefits from those patients. R. 2:327-28. Although Blue Cross continued to accept the electronic submission of claims for benefits on the National Uniform Bill from Rapides, it refused to honor assignments of benefits to Rapides. R. 9:1589.

In October of 2000, after similarly unsuccessful negotiations with Blue Cross regarding rates of reimbursement, Dauterive also terminated its Network Provider Agreement. R. 6:105. Like Rapides, Dauterive continued to treat patients covered by policies and plans insured or administered by Blue Cross, continued to accept assignments of benefits, and continued to submit claims to

Blue Cross electronically on the Uniform Bill, as it had for years. R. 6:1013, 1015. As with Rapides, Blue Cross refused to honor the assignments of benefits to Dauterive and instead paid the claimed benefits directly to participants and insureds. R. 6:1012.

Blue Cross contended that the anti-assignment provisions contained in the plan documents and policies it drafted required it to refuse to honor the assignments of benefits. Pet. 41a. Blue Cross sent benefit checks for services performed by the Hospitals, often for thousands of dollars, directly to plan beneficiaries rather than to the Hospitals themselves. R. 6:1012. On virtually every claim, Blue Cross also paid a benefit to the patient of less than the amount the Hospital billed. R. 6:1010. In many cases, the patients did not remit any of their reimbursement amounts to the Hospitals. *Id.* Consequently, the Hospitals were forced to pursue payment from their patients directly through hundreds of collection lawsuits, garnishments, and seizures of assets. R. 9:1566.

Rapides, and later Dauterive, filed complaints with the Louisiana Department of Insurance ("DOI") concerning Blue Cross's business practices, including its refusal to honor its members' assignments of benefits. R. 2:357-81. In response, the DOI opened an investigation of Blue Cross's claims processing practices and on July 14, 2000, issued a show cause letter to Blue Cross regarding its refusal to honor assignments of benefits in violation of La. Rev. Stat. Ann. § 40:2010. R. 2:356. In response, Blue Cross filed this suit.

Proceedings Below

1. On September 14, 2000, Blue Cross filed a Complaint for Declaratory Relief against Rapides and the State of Louisiana, seeking a declaration that ERISA preempts the Louisiana Assignment Statute. R. 1:1-7. Rapides filed counterclaims against Blue Cross seeking recovery of benefits owed for services rendered to patients covered by ERISA and non-ERISA policies and plans insured or administered by Blue Cross. R. 2:190-200. On August 6,

2001, Dauterive intervened in the suit and alleged claims similar to those asserted by Rapides. R. 2:266-78.

On August 13, 2001, Blue Cross filed a motion for summary judgment seeking a declaration that ERISA preempted the Assignment Statute. R. 2:279-81. On April 15, 2002, the district court denied Blue Cross's motion and found that ERISA did not expressly preempt the Assignment Statute. R. 4:624-39 (*La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 213 F. Supp. 2d 650 (M.D. La. 2002)). The district court agreed with the Hospitals that this Court's jurisprudence required it to "consider the intent and purpose of ERISA," and whether the statute was consistent with those goals. Pet. App. 47a. The court found that "[o]ne of Congress' goals in enacting ERISA was to enhance the health and welfare benefits of employees, and the Louisiana Assignment Statute should not be preempted because it does not interfere with this goal but ... facilitates it." *Id.* The district court then expressly recognized that the statute "constitute[d] a general health care regulation and is within the scope of state law that Congress did not intend ERISA to preempt," *Id.* at 48a. Finding that the statute had "[a]t most, ... an indirect economic effect on ERISA plans," the court concluded that such an effect is "not sufficient to justify a finding that the statute 'relates to' an ERISA plan" and denied Blue Cross's motion for summary judgment. *Id.*

For the next sixteen months, the parties litigated the antitrust, ERISA, and state law claims for damages. In January of 2004, the Hospitals and Blue Cross agreed to settle the parties' damages claims. *Id.* at 5a, R. 8:1529. In conjunction with the settlement, the Hospitals re-entered Blue Cross's provider network. The parties could not resolve the ERISA preemption issue and presented it to the district court for determination. R. 9:1650-53, 1662-63.

On June 17, 2004 the parties filed cross motions for summary judgment. R. 8:1540-42; 9:1585-87, 1645-47. The substance of the motions was largely the same as before, although Blue Cross added a new argument based on

complete preemption in light of this Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). R. 9:1715-19. On October 12, 2004, the district court reaffirmed its prior ruling and rejected Blue Cross's complete preemption argument. R. 10:1820-25.

2. On appeal, the Fifth Circuit affirmed. *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529 (5th Cir. 2006) (Pet. App. 21a). The court began by rejecting Blue Cross's newly-minted argument that *Davila* required a finding of complete preemption because the statute "duplicates, supplements, or supplants" ERISA's exclusive remedies. The Fifth Circuit found the Louisiana statute was "readily distinguishable" from the state law in *Davila* that created a cause of action for the denial of ERISA benefits. Pet. App. 9a. The court explained that the Assignment Statute did not create a new cause of action, but merely provided for the assignment of the cause of action to recover plan benefits created by ERISA itself. *Id.* at 10a. The court was not persuaded that the Assignment Statute required Blue Cross to pay the same benefits twice, reasoning that so long as Blue Cross complies with the assignments, it will only be required to pay once. *Id.* at 11a.

On the express preemption question, the Fifth Circuit held that the Louisiana statute did not "relate to" an ERISA plan. Applying this Court's recent precedents, the court of appeals "start[ed] with the assumption that 'the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress.'" *Id.* at 13a. (citation omitted) (alteration in original). It then explained that the Assignment Statute was a traditional exercise of state power in the area of health and welfare, and was fully consistent with ERISA's goals and policies.

The Fifth Circuit rejected Blue Cross's claim that this Court's decision in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), required a finding of preemption. Unlike the Washington statute in *Egelhoff*, which required payment to a person designated by state law despite the beneficiary's own

designation, the court reasoned the Assignment Statute "is consistent with the express terms of ERISA—leaving the beneficiary determination to *either* the person designated by the participant or the person designated by the plan." Pet. App. 17a. And unlike the statute in *Egelhoff*, the court held, the Assignment Statute would not "impermissibly interfere with nationally uniform plan administration" because it actually reduces paperwork and lessens the burden on insurers. *Id.* at 17a-18a.

The Fifth Circuit acknowledged that the Eighth and Tenth Circuits had concluded that ERISA preempted different state assignment statutes, but held that those decisions were both distinguishable and unpersuasive in light of intervening Supreme Court precedent. *Id.* at 18a. Because the Eighth and Tenth Circuit cases were decided "prior to the Supreme Court's rejection ... of an 'uncritical literalism' in the application of ERISA's 'unhelpful text,'" *id.* at 19a (citation omitted), neither case "operated with the starting assumption that Congress did not intend[] to preempt state law in an area of traditional state regulation." *Id.* at 20a. Finding that Blue Cross failed to overcome that presumption, the court held that ERISA did not expressly preempt the Assignment Statute. As a result, the Fifth Circuit did "not consider whether the statute is saved from preemption as a law regulating insurance." *Id.* at 21a.

Judge Owen concurred. She concluded the court did not need to resolve whether the Assignment Statute "relates to" an employee benefit plan because under the savings clause analysis this Court set forth in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), it was "saved from preemption under 29 U.S.C. § 1144(b)(2)(A) as a law that 'regulates insurance.'" Pet. App. 22a. Under that analysis, she would have held the statute was "specifically directed toward entities that engage in insurance," *id.* at 27a-28a, and that it substantially affected the risk pooling relationship by "alter[ing] the scope of permissible bargains between insurers and insured," *id.* at 29a. Judge Owen also rejected Blue Cross's complete preemption argument.

Blue Cross's petition for rehearing *en banc* was denied on September 15, 2006.

REASONS FOR DENYING THE WRIT

The Fifth Circuit's decision fully conforms to this Court's recent precedents, and the Petition identifies no persuasive justification for review by this Court.

1. The Fifth Circuit's decision is plainly correct. Where, as here, a statute squarely implicates an area of "traditional state power," the Fifth Circuit must presume that Congress did not intend to preempt the Louisiana Assignment Statute, absent evidence that it was "'the clear and manifest purpose of Congress'" to do so. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (citation omitted). There is no such evidence here. As this Court's precedents demonstrate, Congress's decision to remain silent about the scope of assignment or alienation rights in fact suggests an intent *not* to preempt state statutes like this one. Moreover, the Assignment Statute directly serves ERISA's chief purposes, by facilitating the provision of care and benefits to beneficiaries and eliminating Blue Cross's ability to impose unnecessary transaction costs on the entire health care and health insurance system.

The Fifth Circuit's holding is also consistent with all of this Court's modern ERISA preemption jurisprudence. The Petition invokes *Egelhoff*, but there this Court held only that ERISA preempted a state law that *took away* a plan participant's right to designate a beneficiary for pension benefits, and required plan administrators to instead look to a web of state statutes to determine beneficiary status. By requiring insurers to *honor* the beneficiary's assignment of benefits to the participant's health care provider, the statute is consistent with ERISA's goals.

The Fifth Circuit's ultimate conclusion on express preemption is also correct because, as Judge Owen explained, this statute is saved from preemption as a law regulating insurance. Consistent with *Miller*, the Assignment Statute is directed toward entities engaged in

insurance and substantially affects the risk pooling arrangement between the insurer and the insured.

Finally, the Fifth Circuit correctly rejected Petitioner's attempt to analogize this case to the "conflict" or "complete" preemption that this Court recognized in *Davila*. The Assignment Statute does not create any new cause of action to collect ERISA benefits. It simply requires insurers to honor valid state law assignments. Blue Cross's claim that ERISA nonetheless still requires it to pay its insureds directly, because that is what the Plan's language (that it drafted) says, is only true if the Assignment Statute is expressly preempted. This new argument adds nothing.

2. Nor does the Fifth Circuit's decision conflict with decisions of any other circuit. The petition claims a conflict with decisions from the Eighth and Tenth Circuits that were decided *before* this Court substantially altered and narrowed the scope of ERISA preemption beginning with its decision in *Travelers*. Both the Eighth and Tenth Circuits have since recognized that ERISA preemption decisions from the pre-*Travelers* era are no longer controlling or persuasive, and there is no reason to believe that those circuits would continue to follow the decisions creating the alleged split today.

Additionally, the Eighth and Tenth Circuit decisions involved generally applicable assignment principles. The laws in those cases would have permitted assignment of benefits to family members, creditors, and financial institutions and were not, under *Travelers*, clearly entitled to a presumption against preemption. In contrast, the Assignment Statute here only addresses the assignment of health benefits to hospitals that have already provided the underlying care and who are required to submit claims electronically on a National Uniform Bill providing a placeholder for verification. In light of these factual distinctions, there is no reason to conclude that the Eighth and Tenth Circuits would have decided this case any differently.

3. Finally, the Fifth Circuit's opinion is fully consistent with ERISA's objectives and logically follows from this Court's controlling precedents. Review is not warranted to resolve any recurring question or issue of practical import to the health care community.

The Petition identifies no conflict of authority or other issue meriting this Court's review. It should be denied.

I. THE FIFTH CIRCUIT'S DECISION DOES NOT CONFLICT WITH THIS COURT'S PRECEDENTS

The Fifth Circuit properly held that ERISA does not preempt the Assignment Statute. The Petition supplies this Court with no reason to conclude otherwise.

A. The Louisiana Assignment Statute Does Not "Relate To" ERISA Plans

As the Fifth Circuit correctly recognized, any ERISA preemption analysis must begin with this Court's decision in *Travelers*. In *Travelers*, this Court substantially narrowed ERISA's preemptive reach by rejecting the "uncritical literalism" in applying ERISA's "unhelpful text" that had defined prior ERISA preemption jurisprudence. This Court held that where the state law does not explicitly refer to ERISA plans, courts must look to ERISA's "objectives ... as a guide to the scope of the state law that Congress understood would survive," and must start with a presumption "that the historic police powers of the States were not to be superseded ... unless that was the clear and manifest purpose of Congress." 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). This Court further observed that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace *general health care regulation which historically has been a matter of local concern.*" *Id.* at 661 (emphasis added).

Two years later, this Court rounded out the "*Travelers* trilogy." In *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997), this Court held that the presumption that ERISA

did not preempt state wage laws was not overcome where there was an "absence of positive indications on the part of Congress that apprenticeship or prevailing wage statutes would be superseded." 519 U.S. at 331 n.7. And in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 814 n. 10 (1997), this Court reiterated that where a state law "targets only the health industry," "this point supports the application of the 'starting presumption' against pre-emption," and held that ERISA did not preempt a New York law which taxed a hospital owned by an ERISA-covered employee welfare benefit fund.

Applying *Travelers*, the Assignment Statute indisputably implicates areas of traditional state power. Not only is the statute located in the "public health and safety" title of the Louisiana code, but its chief purpose is to streamline the health insurance claims process. Under *Travelers*, the Assignment Statute is therefore entitled to a presumption against preemption. The only remaining question is whether "'it was the clear and manifest purpose of Congress'" to overcome that presumption. 514 U.S. at 655 (citation omitted). The Fifth Circuit correctly held that it was not.

First, as this Court already observed in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 836 (1988), Congress specifically chose to *allow* the assignment of welfare benefits when it enacted ERISA. Tellingly, although ERISA explicitly prohibits the assignment or alienation of pension benefits, *see* 29 U.S.C. § 1056(d)(1), Congress did not similarly bar the assignment of welfare benefits.[1] *Mackey*, 486 U.S. at 836. Thus, in *Mackey*,

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[1] Congress's decision to allow the assignment of welfare benefits but preclude the assignment of pension benefits makes eminent sense. The anti-assignment provision's purpose is "[t]o further ensure that the employee's accrued benefits are actually available for retirement purposes." H.R. Rep. No. 93-807, at 68 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4734. As discussed *infra*, Congress intended that welfare benefits be paid out to cover immediate health care expenses—a goal that is furthered, not obstructed, by the Assignment Statute.

because Congress's silence "concerning the assignment or garnishment of ERISA welfare plan benefits" reflected a decision to "'acknowledge[] and accept[] the practice, rather than prohibiting it,'" the Court held that ERISA did not preempt a state law allowing garnishment of an employee welfare benefit plan. 486 U.S. at 837-38 (citation omitted). Surely if Congress allowed a collection agency to use state law to garnish an employee welfare benefit plan, it failed to voice a "clear and manifest" intent to preempt a state law allowing a health care provider (designated as a plan participant's assignee) to recover plan benefits.

ERISA's definition of "beneficiary" confirms that conclusion. Congress defined a "beneficiary" as "*a person designated by a participant*, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8) (emphasis added). Petitioner's claim that Congress manifestly intended to preempt state laws allowing an assignment cannot be squared with Congress's obvious intent to create a class of beneficiaries through assignment. Consistent with *Mackey* and the definition of "beneficiary," several courts of appeals have interpreted ERISA's text as allowing assignments[2]—further proof that Congress did not express any clear and manifest intent to preempt statutes like this one.

Second, the Assignment Statute plainly comports with ERISA's objectives. Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); *see also* 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this Act to protect ... the interests of participants in employee benefit plans and their beneficiaries ...."). The Assignment Statute furthers

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2 *See, e.g., City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 226 (1st Cir. 1998); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464 (10th Cir. 1995); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991); *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).

ERSA's purposes because it "facilitates rather than hampers the employee's receipt of health benefits," *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 & n.13 (5th Cir. 1988), by enabling patients to promptly recoup their benefits without having to seek reimbursement following an out-of-pocket payment. Patients who cannot pay in advance are particularly benefited. Without assignment, those patients would likely not seek the requisite health care (thereby putting off necessary treatment until a costly emergency), and providers might avoid serving those patients because of the risk of nonpayment.

Honoring assignments also increases efficiencies. The Louisiana Assignment Statute increases the likelihood that patients receive their benefits and that hospitals are compensated. Moreover, it allows hospital claims specialists to deal directly with insurers and more efficiently navigate the complicated maze of claim forms and procedures required to obtain relief. As Petitioner conceded at the district court, the consolidated electronic filing process used by hospitals is more efficient and is beneficial to *both insurers and providers*. R. 2:211-28. Under Louisiana law, hospitals provide proof of loss on the UB-92 claim form or HCFA Form 1500 (or its successor), La. Rev. Stat. Ann. § 22:214.3(A) (2007)—forms that are both promulgated by the Centers for Medicaid and Medicare Services and include a space for a beneficiary to assign his benefits. R. 2:327-328 (Ex. 3). The Assignment Statute thus simply requires that ERISA plan administrators acknowledge an assignment designated on a routine federal government claim form they must process daily anyway. Pet. App. 17a-18a. Indeed, Blue Cross conceded that "it must honor assignments made under non-ERISA plans, which suggests that it already has in place some administrative mechanism for complying with the statute." *Id.* at 18a. Allowing beneficiaries to assign their benefits to a provider does not upset the plan's administration or impose additional costs on the insurer.

In contrast, an insurer's refusal to honor assignments burdens the entire health care and health insurance systems with the deadweight transaction costs associated with indirect reimbursements, and the attendant unnecessary litigation, thereby increasing costs and premiums and/or decreasing benefits for everyone. When assignments are not honored and a plan does not properly pay benefits, the healthcare provider either must rely on the beneficiary to bring an ERISA suit and then intervene in the action pursuant to Rule 24, or, worse, sue the beneficiary. Moreover, under *Mackey*, a hospital that provided services to a plan participant and is not paid can sue the participant directly, obtain a judgment, and then garnish the benefit plan to recover payment. Honoring assignments avoids such unnecessary effort, expense, and turmoil while still paying the participant's medical bills.

Blue Cross's policy arguments boil down to its claim that the ability to bar assignment increases Blue Cross's leverage over those hospitals in "network" negotiations, which, Blue Cross claims, it uses (in part) to negotiate lower prices. Of course the same would be true of any state law giving Blue Cross control over something that hospitals need, and here the countervailing cost is a serious blow to the efficiency of claims administration and to the prompt payment of benefits to beneficiaries, including beneficiaries of ERISA covered plans. In this area of traditional state regulation, Louisiana is entitled to conclude that whatever social benefit might be produced by giving Blue Cross yet another club to wield in negotiations is not worth the social costs. Nothing in ERISA demonstrates any clearly manifested contrary intent on the part of Congress.

Blue Cross invokes this Court's decision in *Egelhoff*, but that case is fully consistent with the Fifth Circuit's reasoning here. In *Egelhoff*, this Court held that ERISA preempted a Washington statute that, by operation of law, revoked the designation of a spouse as the beneficiary of all non-probate assets—including ERISA plan benefits—after the marriage ended. *See* Wash. Rev. Code § 11.07.010(2)(a)

(1994). This Court concluded ERISA preempted the Washington statute because the statute forced ERISA plan administrators to pay benefits to persons "chosen by state law," 532 U.S. at 147, rather than to the beneficiary's own designee, and because it burdened plan administration by forcing administrators to look outside the plan documents and the beneficiary's own elections to determine beneficiary status. *Id.* at 148-49 (noting that, under the Washington statute, plan administrators "must familiarize themselves with state statutes so that they can determine whether the named beneficiary's status has been 'revoked' by operation of law").

The Petition argues that the Fifth Circuit "failed to follow [*Egelhoff*'s] overriding instruction to evaluate the validity of a state statute by considering its impact on the ERISA objectives of ensuring that plan administration, and benefit payment, occur in accordance with valid plan provisions." Pet. 16. That is incorrect. The Fifth Circuit rightly concluded that the chief concerns animating this Court's decision in *Egelhoff* are not present here.

First, the court correctly observed that unlike the statute in *Egelhoff*, the Louisiana Assignment Statute does not designate by law a beneficiary that is outside of the two classes of "beneficiaries" ERISA permits, *see* 29 U.S.C. § 1002(8) (defining beneficiary as a plan participant or person "designated by a participant"), let alone a beneficiary that nullifies the plan participant's preference. Far from supplanting the free will of the ERISA plan participant, the Louisiana statute protects it. Pet. App. 15a. Petitioner claims that the Fifth Circuit's interpretation "gives short shrift to the express statutory terms" because administrators are obligated to pay beneficiaries who are "'designated by a participant ... *who is or may become entitled to a benefit thereunder*,'" Pet. 15 (quoting 29 U.S.C. § 1002(8) (emphasis in Petition). That is an overly technical reading—particularly in light of *Travelers* admonition against "uncritical literalism" in ERISA's application.

Second, the Fifth Circuit correctly concluded the statute's "burden on plan administrators is minimal." Pet. App. 17a. Rather than forcing ERISA plan administrators to look to a morass of state statutes to determine potential beneficiaries, *see Egelhoff*, 532 U.S. at 148-49, the court found the Louisiana Statute, by using the National Uniform Bill, creates no additional paperwork for plan administrators who do not pay benefits until they receive that claim form. Pet. App. 17a-18a. Petitioner thus brought substantial administrative burdens *on itself* in a convoluted effort to avoid complying with this eminently sensible law.

B. The Louisiana Assignment Statute Is Saved From Preemption As A Law Regulating Insurance

The Fifth Circuit's judgment also does not conflict with *Egelhoff* because the statute falls within ERISA's savings clause. 29 U.S.C. § 1144(b)(2)(A) (2006) (providing that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance"). As Judge Owen's concurrence explains, the Louisiana Statute is "saved from preemption ... as a law that 'regulates insurance.'" Pet. App. 22a.

In *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003), this Court held that to be saved from preemption (1) "the state law must be specifically directed toward entities engaged in insurance" and (2) "the state law must substantially affect the risk pooling arrangement between the insurer and the insured." This Court applied those factors in *Miller* to hold that Kentucky's "Any Willing Provider" ("AWP") statute—which required health insurers to accept in their plan any provider willing to meet the terms for participation established by the insurer—was saved from preemption. *Id.* at 331-32. First, this Court rejected the insurers' claim that the AWP statute was not "specifically directed toward" insurers because the law had the effect of preventing providers from creating their own preferred provider networks with insurers. The law's effect on the conduct of parties outside the insurance

industry did not diminish the fact that it was directed at insurers. *Id.* at 334-36. This Court also rejected the insurers' claim that the AWP law failed to control the actual terms of an insurance policy, but instead regulated "the relationship between an insurer and third-party provider." *Id.* at 337. Second, this Court concluded that while the statute did not alter the terms of insurance policies, it did substantially affect the risk pooling arrangement because it "expand[ed] the number of providers from whom an insured may receive health services" and "alter[ed] the scope of permissible bargains between insurers and insureds." *Id.* at 338-39.

As Judge Owen correctly reasoned, the Assignment Statute qualifies as a law regulating insurance under *Miller*. First, the Statute is indisputably "directed toward entities that engage in insurance." As the text suggests, the Louisiana legislature's purpose was to streamline the insurance claims process and to require any entity serving in an *insurance capacity* to recognize a beneficiary's assignment of insurance benefits.[3] La. Rev. Stat. Ann. § 40:2010 ("No *insurance* company, employee benefit trust, self-insurance plan, *or other entity which is obligated to reimburse the individual* ....") (emphasis added); *cf. Wash. State Dep't of Social & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 384 (2003) ("'[W]here general words follow specific words ... the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific

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[3] The petition asserts that "[t]he panel's decision ... is so broadly worded that, arguably, it impacts all ERISA plans, includ[ing] self-funded as well as insured plans." Pet. 26. The Louisiana Commissioner of Insurance stated, however, that "the Department does not enforce the Louisiana assignment statute against ERISA plans or their administrators. It enforces the statute only against insurers acting as insurers." R. 9:1553 (Ex. B, Declaration of J. Robert Wooley, ¶¶ 4-5). The Fifth Circuit thus stated that "[t]his case asks us to decide whether [ERISA] preempts the assignment statute to the extent that it applies to fully insured ERISA plans." Pet. App. 1a-2a.

words.'").[4] Indeed, Petitioner brought this action in response to an investigation by the *Louisiana Department of Insurance* conducted pursuant to the insurance code, La. Rev. Stat. Ann. § 22:1214(12). Petitioner cannot credibly argue that the Assignment Statute does not regulate insurers "'with respect to their insurance practices.'" *Miller*, 538 U.S. at 334 (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366 (2002)).

Second, the Louisiana statute "substantially affects the risk pooling arrangement between the insurer and the insured in much the same way as the state law at issue in [*Miller*]," Pet. App. 29a (Owen, J., concurring), by "alter[ing] the scope of permissible bargains between insurer and insured." 538 U.S. at 338-39. The Assignment Statute alters the behavior of insureds in ways that both decrease and increase the insurers' losses, thereby affecting the premiums the insurer can charge. For example, the statute prevents the addition of a new layer of risk by reducing the hazard resulting from the payment of benefits directly to insureds, who might fail to pay the hospital that actually provided the services.[5] Such insureds would have an incentive to over-utilize medical services, increasing the

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[4] The statute's placement in the "Public Health and Safety" title does not diminish that fact. *See, e.g., Standard Sec. Life Ins. Co. of N.Y. v. West*, 267 F.3d 821 (8th Cir. 2001) (holding that statute outside the insurance code nevertheless fell within the scope of the savings clause); *Mut. Reinsurance Bureau. v. Great Plains Mut. Ins. Co.*, 969 F.2d 931 (10th Cir.) (same), *cert. denied*, 506 U.S. 1001 (1992). To hold that it does require a finding of preemption would not only grossly oversimplify the ERISA preemption analysis contrary to the legislature's intent, *see* La. Rev. Stat. Ann. § 1:12 ("The classification and organization of the sections of the ... Statutes is made for the purpose of convenience, reference, and orderly arrangement, and no implication or presumption of a legislative construction shall be drawn therefrom."), but would ignore the fact that the Assignment statute is one part of an interlocking set of laws Louisiana has enacted to regulate the health insurance claims process.

[5] R. 9:1551 (Ex. C, Declaration of Sean McIntosh). This expert opinion is the only evidence in the record on this topic, and the Petitioner has made no effort to challenge its substantive conclusions.

risk for which the insurer and insured are contracting. On the other hand, Blue Cross argues that the Assignment Statute limits the permissible bargains between the insurer and insured in a way that actually *increases* the risk for which they are contracting, by limiting Blue Cross's ability to negotiate down the price of medical services.

Indeed, the parallels with *Miller* are particularly strong because the Assignment Statute increases the number of hospitals to which plan participants have effective access. Just as the AWP statute affected risk pooling because Kentucky insureds could no longer "seek insurance from a closed network of health-care providers in exchange for a lower premium," *Miller*, 538 U.S. at 338-39, the Louisiana statute prevents insurers from limiting assignments to a closed network of health-care providers in exchange for lower premiums. By expanding the pool of hospitals willing to treat Petitioner's insureds, the Louisiana statute, like the AWP statute in *Miller*, directly affects the type of risk pooling arrangements insurers may offer.

The statute's overriding emphasis on insurance also explains why this case is entirely different from—and not controlled by—*Egelhoff*. Although Petitioner protests that, by requiring an insurer to recognize an assignment, the statute compels it to violate the terms of its ERISA plan, Pet. 15, this Court has already expressly rejected that argument in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375 (1999), *overruled on other grounds by Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), where it held that the "'contra plan term' argument overlooks controlling precedent and makes scant sense." This Court noted that, under Petitioner's argument, "States would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents." *Id.* at 376. That "interpretation would virtually 'read the saving clause out of ERISA.'" *Id.* (citation omitted).

In sum, the Assignment Statute's obvious regulation of insurance compels the conclusion that it would be saved from preemption even if it did "relate to" ERISA plans within the meaning of the express preemption clause.

C. The Fifth Circuit's Decision Does Not Conflict With This Court's Application Of Conflict Preemption Principles In *Davila*

Apart from its express preemption arguments, the Petition also contends that the Fifth Circuit's opinion "conflicts with Supreme Court authority requiring preemption of state laws that conflict with ERISA's exclusive enforcement mechanism"—specifically, this Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). Pet. 20. Petitioner argues that the Assignment Statute conflicts with ERISA's civil enforcement scheme because it somehow creates a new cause of action and allows for double recovery against an ERISA plan. This argument, which the Fifth Circuit unanimously rejected, is a purposeless sideshow.

In *Davila*, the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-88.003, authorized the plaintiffs to bring a medical malpractice claim against their HMOs based on injuries they allegedly suffered due to the HMO administrators' decision not to provide coverage for treatment recommended by the plaintiffs' physicians. Relying on ERISA's plain text, this Court held that the plaintiffs' attempt to subject their HMO to liability for coverage decisions duplicated the cause of action under ERISA § 502(a)(1)(b) which allows a plan participant to recover wrongfully denied benefits. This Court reaffirmed that, under the complete preemption doctrine, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." 542 U.S. at 209.

Petitioner cannot shoehorn this case into the *Davila* framework because the Assignment Statute does not create

any new cause of action. As the Fifth Circuit correctly observed, on its face "the assignment statute does not create an additional means to enforce payment of benefits under an ERISA plan." Pet. App. 10a. It simply regulates the assignment of the federal cause of action created by § 502 of ERISA. And the Petition identifies no evidence that Louisiana courts have recognized any implied private right of action to enforce the Assignment Statute, or that the state legislature ever contemplated such a right of action.

Petitioner argues that the Assignment Statute violates *Davila* because it "contemplates a double payment of the same benefit." Pet. 23. It claims that under ERISA it *must* pay the beneficiary regardless of whether, consistent with the Assignment Statute, the beneficiary has assigned his or her benefits to the hospital. *Id.* But that circular argument simply assumes that ERISA preempts the Assignment Statute. If the Assignment Statute is not preempted and there is a valid assignment, then the insurer is not obligated to pay the beneficiary rather than the assignee. Thus, "[i]f Blue Cross complies with the assignment, then it only pays one time; if Blue Cross ignores the assignment, then it risks paying a claim twice." Pet. App. 11a. Moreover, Petitioner's own policy language requires it to respect assignments "as required by law." R. 2:306. Blue Cross faces a conflict between its obligations under the Assignment Statute and its obligations under its policy language only if the Assignment Statute is expressly preempted—in which case this complete preemption argument adds nothing.[6]

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[6] The Petition's related claim that the Assignment Statute "enlarges the claim" available under ERISA "because it requires Blue Cross to pay money to the hospital even if it has already paid benefits to the participant" is similarly without merit. Pet. 24. As the Fifth Circuit unanimously observed, the Assignment Statue does not enlarge the rights or remedies of beneficiaries because "[t]he assignee takes what the assignor had; no more, no less." Pet. App. 10a; *see also id.* at 32a (Owen, J., concurring) (noting the statute "simply directs to whom payment must be made once there has been a valid assignment").

II. THE PETITION IDENTIFIES NO CONFLICT IN THE LOWER COURTS THAT IS APPROPRIATE FOR REVIEW

The Petition argues that the Fifth Circuit's decision conflicts with the Eighth Circuit's decision in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992), and the Tenth Circuit's decision in *St. Francis Regional Medical Center v. Blue Cross & Blue Shield of Kansas, Inc.*, 49 F.3d 1460 (10th Cir. 1995), both of which held that ERISA expressly preempted assignment statutes of general applicability. Pet. 17. The claimed split is ephemeral. The Eighth and Tenth Circuit decisions, decided 16 and 12 years ago respectively, rested entirely on jurisprudence this Court explicitly disavowed in *Travelers*. Since *Travelers*, only the Fifth Circuit has considered whether ERISA expressly preempts a state assignment statute (general or specific). It is therefore premature to review the issue. Moreover, because the Eighth and Tenth Circuit cases involved generally applicable assignment statutes that were not specifically directed at the assignment of health insurance policies to hospitals, those cases are also distinguishable on their facts and do not facially implicate the savings clause. In short, there is no reasonable basis to conclude that either the Eighth or the Tenth Circuits would decide *this* case, *today*, any differently from the Fifth Circuit.

A. Review of The Alleged Conflict Is Premature Because The Lower Courts Have Not Considered The Application Of Intervening Supreme Court Precedent

1. In *St. Mary's*, the Eighth Circuit held that ERISA preempted Arkansas's "generally applicable" assignment statute where an insured assigned its rights under the ERISA plan to a health care provider. The Eighth Circuit's analysis was based on a multi-factor test that it extrapolated from several other courts of appeals decisions. 947 F.2d at 1344-45 (relying on factors from Second, Fifth, Sixth, and

Ninth Circuits decisions). Its analysis of many of those factors is plainly untenable after *Travelers*.

First, the Eighth Circuit started from the assumption that this Court "broadly interpret[s]" ERISA's express preemption clause, 947 F.2d at 1344, and it *explicitly disclaimed* any consideration of traditional state powers as a factor, concluding that it was, at best, "arguably ... a policy consideration useful in deciding borderline questions of ERISA preemption." *Id.* at 1350 ("[W]e are 'not convinced that ... the traditional or nontraditional nature of the state law ... properly bears upon'" the express preemption question. (citation omitted) (omissions in original)). *Travelers*, of course, squarely rejected both assumptions and implemented a clear presumption *against preemption* that applies in cases involving regulation of "traditional state powers." 514 U.S. at 655.

Second, the Eighth Circuit examined ERISA's text and legislative history and reasoned that preemption was appropriate in light of Congress's silence on the assignment of welfare benefits. *St. Mary's*, 947 F.2d at 1349 (reasoning that if Congress had wanted to preserve a role for state assignment law, it could easily have done so). That presumption in the preemption context is entirely wrong after *Travelers*—which requires courts to examine ERISA's text and legislative history for evidence that Congress intended to *overcome the presumption against preemption.* 514 U.S. at 655.

Third, the Eighth Circuit held that, because the Arkansas statute eliminated an incentive Blue Cross used to reward favored hospitals, it increased health care costs and caused "an economic impact on ERISA plans" warranting preemption. 947 F.2d at 1348-49. But the *Travelers* trilogy expressly rejected Petitioner's reasoning and held that an "economic effect" on an ERISA plan was insufficient to justify preemption where that economic effect merely "alters the incentives, but does not dictate the choices, facing ERISA plans," *Cal. Div. of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316, 334 (1997).

The Eighth Circuit is not blind to these changes in the law. In *Wright Electric, Inc. v. Minnesota State Board of Electricity*, 322 F.3d 1025, 1029 (8th Cir. 2003), it not only acknowledged that "'*Travelers* plainly signaled a significant analytical shift in regard to ... the ERISA preemption inquiry, abandoning strict textualism in favor of more nuanced approach'" (citation omitted), but also declined to follow its prior decision in *Boise Cascade Corp. v. Peterson*, 939 F.2d 632 (8th Cir. 1991), *cert. denied*, 505 U.S. 1213 (1992)—decided just three months before *St. Mary's*—on the grounds that it was "no longer controlling in light of intervening Supreme Court cases, beginning with [*Travelers*]." The Eighth Circuit has not yet had the opportunity to reexamine *St. Mary's* holding in light of the *Travelers* trilogy, but there is no reason to believe it would adhere to that decision today.

2. The same holds true for the Tenth Circuit's decision in *St. Francis*. Although the Tenth Circuit's ERISA preemption analysis is less thorough than the Eighth Circuit's analysis in *St. Mary's*, it is no less antiquated. Like the Eighth Circuit, the Tenth Circuit "construe[d] ERISA's preemptive scope broadly," did not apply a presumption against preemption, did not consider the argument that the court should defer to the states' traditional powers in the area of health care, and interpreted congressional silence as favoring preemption. 49 F.3d at 1464. And the Tenth Circuit has also acknowledged that pre-*Travelers* jurisprudence relied on assumptions that are no longer tenable. In *Willmar Electric Service, Inc. v. Cooke*, 212 F.3d 533, 537 (10th Cir.), *cert. denied*, 531 U.S. 979 (2000), the Tenth Circuit refused to rely on pre-*Travelers* jurisprudence (including the Eighth Circuit's opinion in *Boise Cascade*) in resolving an ERISA express preemption question, noting that "these cases are not persuasive because they preceded the Supreme Court's delineation of the limits of ERISA preemption in cases such as *Travelers*, *Boggs*, *Dillingham*, and *DeBuono*." There is every reason

to conclude that the Tenth Circuit would not regard *St. Francis* as good law today.

The alleged "split" is therefore illusory and obsolete. If the Circuits genuinely view these issues differently in the wake of the *Travelers* trilogy, there will be plenty of opportunities for them to articulate their positions. Twenty-one states have statutory assignment provisions.[7] These states are located in nine different circuits,[8] including the Eighth and Tenth Circuits, which could reconsider the issue in light of this Court's recent precedent. This Court will have ample opportunity to review the issue if a true conflict emerges.

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[7] The following states have statutes requiring an insurer to pay benefits directly to a provider of healthcare services in certain situations: Alabama (Ala. Code § 27-1-19(a)–(b)); Alaska (Alaska Stat. § 21.54.020(a), Alaska Stat. § 21.51.120(a), Alaska Stat. § 21.54.050(a)); Arkansas (Ark. Code Ann. § 4-58-102); California (Cal. Ins. Code § 10133, Cal. Ins. Code § 10133.7(a)); Colorado (Colo. Rev. Stat. § 10-16-106.7(1)(a), Colo. Rev. Stat. § 10-16-317.5); Connecticut (Conn. Gen. Stat. § 38a-491b, Conn. Gen. Stat. § 38a-517b)); Florida (Fla. Stat. Ann. § 627.638(2)); Georgia (Ga. Code Ann. § 33-24-54(a), Ga. Code Ann. § 33-24-59.3(b)); Louisiana (La. Rev. Stat. Ann. § 40:2010); Maine (Me. Rev. Stat. Ann. tit. 24, § 2332-H, Me. Rev. Stat. Ann. tit. 24-A, § 2755, Me. Rev. Stat. Ann. tit. 24-A, § 2827-A, Me. Rev. Stat. Ann. tit. 24-A, § 4207-A(5-A)); Nevada (Nev. Rev. Stat. Ann. § 689A.135); New Hampshire (N.H. Rev. Stat. Ann. § 420-B:8-n(VIII)); Ohio (Ohio Rev. Code Ann. § 3901.386); Oklahoma (Okla. Stat. tit. 36, § 6055(D)–(E)); Rhode Island (R.I. Gen. Laws § 27-18-63), R.I. Gen. Laws § 27-19-54, R.I. Gen. Laws § 27-20-49, R.I. Gen. Laws § 27-20.1-18, R.I. Gen. Laws § 27-41-66); South Dakota (S.D. Codified Laws § 58-17-61); Tennessee (Tenn. Code Ann. § 56-7-120); Texas (Tex. Ins. Code Ann. § 1204.053, Tex. Ins. Code Ann. § 1204.054, Tex. Ins. Code Ann. § 1251.005); Virginia (Va. Code Ann. § 38.2-3407.13, Va. Code Ann. § 38.2-4215); Washington (Wash. Rev. Code § 48.44.026); Wyoming (Wyo. Stat. Ann. § 26-15-136(b)).

[8] The following circuits have states with assignment statutes: First (Maine, New Hampshire, Rhode Island), Second (Connecticut), Fourth (Virginia), Fifth (Louisiana, Texas), Sixth (Ohio, Tennessee), Eighth (Arkansas, South Dakota), Ninth (Alaska, California, Nevada, Washington), Tenth (Colorado, Oklahoma, Wyoming), and Eleventh (Alabama, Florida, Georgia).

B. The Alleged Conflicts Are Illusory Because The Eighth And Tenth Circuits Have Analyzed ERISA Preemption In The Context Of Vastly Different State Statutes

Additionally, substantial factual differences between the generally applicable assignment principles at issue in the pre-*Travelers* Eighth and Tenth Circuit decisions and the far narrower Louisiana Assignment Statute cast considerable doubt on the alleged split.

1. The Arkansas assignment statute the Eighth Circuit considered in *St. Mary's* bore virtually no similarity to the Louisiana Assignment Statute. That statute provided that "'[a]ll bonds, bills, notes, agreements, and contracts in writing, for the payment of money or property, or for both money and property, *shall* be assignable.'" 947 F.2d at 1343 (quoting Ark. Code Ann. § 4-58-102 (1987)). The Eighth Circuit held that ERISA preempted that statute where a beneficiary sought to assign its rights to a health care provider. For at least three reasons the Petitioner ignores, that holding does not establish a conflict with the Fifth Circuit's decision below.

First, the statutes have substantially different effects on ERISA plan administration. The Arkansas statute allowed beneficiaries to "pay a provider with personal funds and assign their welfare benefits to third parties" such as family members, creditors, or financial institutions. 947 F.2d at 1347. The Eighth Circuit reasoned that "[s]uch assignments would create numerous administrative hassles because there is no mechanism for providing the insurer with notice of these assignments and, potentially, the administrator would have to cope with conflicting assignments." *Id.* The Louisiana Assignment Statute does not suffer from any of those dangers because it only requires administrators to respect assignments of health insurance benefits to the hospital that actually provided the care, on a standard form that eliminates any risk of double assignment.

Similarly, the Eighth Circuit summarily found in *St. Mary's* that requiring the insurer to recognize assignments

complicated ERISA plan administration because it required insurers to change their practices and look to the National Uniform Bill (there, a UB-82 form) in processing claims. *Id.* at 1347. Under Louisiana law, however, Petitioner *already* must use the standard government form. The Fifth Circuit thus observed that the "assignment statute will not create any additional paperwork for Blue Cross and, in fact, *it may lessen Blue Cross's administrative responsibilities.*" Pet. App. 17a-18a (emphasis added) (stating "the burden on plan administrators is minimal"). Indeed, the court noted, "[t]he burden seems greater when many individuals [sic] plan participants must each individually file claims with Blue Cross ...." *Id.* at 18a.

Second, there are substantial *legal* distinctions between a statute which allows anyone to assign virtually anything to anyone else and a statute that requires an insurer to recognize a insured's assignment of health insurance benefits to the health care provider that provided the care. The Arkansas Assignment Statute did "not directly regulate health care costs" specifically, and did not regulate an area of traditional state authority. 947 F.2d at 1350-51. The Eighth Circuit could not have made the same finding with regard to the Louisiana statute, which is located in the "public, health, and safety" code and indisputably regulates an area of traditional state authority. The Eighth Circuit found regulation of traditional state authority important for "borderline cases," and reasoned that the absence of such regulation tipped the scales in *St. Mary's*. It clearly would have reached the opposite conclusion if faced with this statute, to say nothing of the conclusion it would have reached post-*Travelers*.

Third, there could not be any split on the ultimate issue of ERISA preemption because the Eighth Circuit did not reach the dispositive issue of whether the Arkansas statute was saved from preemption as a law regulating insurance. In other factual circumstances involving laws facially regulating insurance (and thus more analogous to the statute at issue here), the Eighth Circuit has applied the

savings clause to hold a statute is not preempted. *See, e.g., United of Omaha v. Bus. Men's Assurance Co. of Am.*, 104 F.3d 1034, 1041-42 (8th Cir. 1997). Thus, even if the Eighth and Fifth Circuit did disagree on the "relates to" question (which is far from clear), there is every reason to believe they would have reached the same conclusion here.

b. The Tenth Circuit's decision in *St. Francis* presents an even weaker candidate for a split. Contrary to the Petition's misleading assertion, the Tenth Circuit did not consider an "analogous state statute." Pet. 17. There was no statute. Instead, the Tenth Circuit considered whether ERISA preempted Kansas *public policy* (as articulated and developed through state common law decisions) favoring assignments. Kansas had enacted a law that expressly authorized Blue Cross Blue Shield of Kansas to refuse to honor assignments. Following Blue Cross's conversion from a non-profit to a mutual insurance company, St. Francis (a provider) sought a declaration that Blue Cross's continued refusal to honor assignments was against non-statutory Kansas public policy. *See St. Francis Reg'l Med. Ctr. v. Blue Cross Blue Shield of Kan., Inc.*, 810 F. Supp. 1209, 1211 (D. Kan. 1992) ("St. Francis contends that the non-assignment clause utilized by Blue Cross ... violates the Kansas public policy supporting free assignment of [cau]ses of action."). Blue Cross removed to federal court and claimed that ERISA preempted the common law public policy. The Tenth Circuit agreed.

Like the Arkansas law considered in *St. Mary's*, the Kansas public policy in *St. Francis* was a generally applicable principle favoring assignment of all obligations, to anyone. The Tenth Circuit's cursory reasoning is therefore distinguishable for all the reasons discussed above. Moreover, the amorphous nature of the Kansas public policy and the absence of any real record facts at the motion to dismiss stage may have made a more thorough analysis impossible. *St. Francis*, 49 F.3d at 1465 n.6 ("The district court ruled as a matter of law" on the preemption question "and hence did not rest its holding on any factual

considerations."). The court also did not evaluate the plan administration, the economic impact of the state law on ERISA plans, or whether the state law regulated an area of traditional state concern. Instead, the court's finding of preemption rested exclusively on its conclusion that because "ERISA itself is silent on the issue of assignability of benefits in insurance plans," Congress must have left "the assignability of benefits to the free negotiations and agreement of the contracting parties." *Id.* at 1464.

Applying pre-*Travelers* precedent and "construl[ing] ERISA's preemptive scope broadly," the Tenth Circuit gave no consideration to whether Congress left a question falling within a traditional area of state regulation *to the states* rather than to the contracting parties. *Id.* Because Kansas public policy did not purport to regulate insurance particularly, the Tenth Circuit had no occasion to consider whether the savings clause applied.[9]

III. THE PETITION DOES NOT RAISE ANY IMPORTANT QUESTION WARRANTING THIS COURT'S REVIEW

In the absence of a conflict, the Petition also claims that review is necessary "to provide guidance on matters of public policy and federal preemption." Pet. 25-26. No such guidance is necessary or appropriate at this time.

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[9] In one sentence, the Petition also argues the Fifth Circuit's decision conflicts with the First Circuit's decision in *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223 (1st Cir. 1998), the Eleventh Circuit's decision in *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291 (11th Cir.), *cert. denied*, 543 U.S. 1002 (2004), as well as the Fifth Circuit's own decision in *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348 (5th Cir. 2002). Pet. 18-19. These decisions hold (unremarkably), that under ERISA parties are free to enter contracts restricting assignment. The courts had no reason to consider and did not address the significance of a state law regulating assignment, let alone whether such a law would be preempted and are therefore not in conflict with the decision below. And even if they were in conflict, the presence of an intra-circuit split is reason enough for this Court to deny review.

The Petition vastly overstates the Assignment Statute's effect on the health insurance industry. Petitioner claims that, despite its undeniable efficiencies, mandated honoring of assignments raises health care costs because it "eliminates" the leverage that insurers have to induce participation in their provider networks (and thereby to implement cost controls). Pet. 26. As Petitioner knows, insurers have many weapons in their arsenal to "induce" out-of-network providers, including the power to offer different (and less beneficial) reimbursement rates for out-of-network providers. Petitioner can use those methods to exert as much pressure on hospitals as its own power in the marketplace will allow.

By the same token, consumers and employers who know the differences in benefits can make an informed decision whether the purported savings from such methods are sufficient to offset the resulting loss of access to their preferred healthcare providers. Presumably that is why Blue Cross does not want to exert its market leverage in such an up-front manner. Blue Cross's own customers want to use their preferred hospitals, and might strongly consider alternatives if they routinely received bills for excess charges because Blue Cross refused to provide reasonable coverage at those preferred hospitals. Refusing to honor assignments, however, imposes painful costs, both monetary and intangible, on out-of-network hospitals and on plan participants and beneficiaries, and does so in a way that focuses the negative attention on the hospitals that are required to pursue the insured for payment, rather than on a defect in the insurance coverage. Blue Cross's desire to coerce providers into network so that it can lower reimbursement rates in a way that its insureds will not notice or understand serves no broader public interest. Blue Cross is free to discriminate aggressively in favor of its in-network providers, but it should do so forthrightly and in a manner that does not impose large, unnecessary deadweight transaction costs on the whole health care system.

Blue Cross also identifies no record evidence to support its claim that requiring it to recognize assignments will "discourage employers from establishing plans." Pet. 26. The absence of record evidence in its favor is not surprising. Petitioner does not seek to reverse a decision that unsettled the health care industry; rather it invites this Court to unsettle that industry by authorizing Blue Cross to deviate from the way it and the vast majority of insurers ordinarily do business. The assignment-of-benefits process has become the industry standard for private insurance companies—indeed, the record shows that Blue Cross itself was not equipped to handle the chaotic consequences of refusing to honor assignments, resulting in reimbursement delays and unpaid medical bills to providers. R. 9:1566. That is not surprising. Honoring assignments lowers the costs of ERISA plan administration and serves ERISA's purposes by streamlining the reimbursement process and guaranteeing that insurance funds make their way to the provider. Pet. App. 48a. That, in turn, lowers costs and premiums, improves access to health care, encourages participants to regularly seek health care, and particularly helps the increasingly large segment of the population that cannot afford to pay in advance for their treatment.

Finally, the decision below does not demonstrate that ERISA preemption jurisprudence is ambiguous or uncertain. *Travelers* and its progeny provide a straightforward framework for analyzing whether ERISA preempts a statute regulating health benefit plans, which the Fifth Circuit correctly applied to conclude that ERISA does not preempt the Assignment Statute.

CONCLUSION

For the reasons set forth above, the Petition for certiorari should be denied.

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